SPECTRA
support services, llc

Welcome Packet

Greetings! We are honored to have you/your child participate in psychological evaluations with our agency. This welcome packet includes information about our policies and includes important forms for you to fill out. Please read carefully and complete the relevant forms in preparation for your next visit.

For Assistance Contact Our Intake Coordinator

Karen Weiss, LSW
intake@spectrapa.com
484-450-6476, ext. 710

475 Lawrence Road
Broomall, PA 19008
Spectrapa.com

Revision Date: 2/3/18

SPECTRA
support services, llc

Table of Contents

WELCOME TO SPECTRA SUPPORT SERVICES, LLC

Greetings! We are so excited to have you/your child participate in programming here at our agency. This documentation packet will help us to clarify our policies and provide you with vital information. Please read it carefully and let us know if you have any questions. For assistance contact our intake coordinator Karen Weiss, LSW at 484-450-6476, ext. 710. We ask that you complete the forms requiring information or signatures (beginning on page 17) and bring them to your first appointment.

At Spectra, we strive to provide support to all family members. Please check out our website or bulletin board for the most up-to-date programming offerings. Feel free to make an appointment for a consultation to see if there may be other ways in which we may serve you. Please note that we rent space from, but are not affiliated with any religious group or organization, including Marple Christian Church.

Waiting Area

While you are waiting at our office, please feel free to:

- Wait in the waiting area in the hallway
- Grab a magazine, children's game or toy
- Sit quietly in the church's sanctuary
- Grab a cup of coffee in our kitchen
- Take a walk on our beautiful grounds.

Local Amenities

We are located close to:

- Lawrence Park Shopping Center (Acme, CVS, Dollar Store & more)
- Wawa
- Wendy's
- Home Depot

Some who have travelled a distance ask for ideas for local playgrounds. We recommend the following:

- Veteran's Park (Lawrence Road)
- Paddock Park (Lawrence to West Chester Pike to Eagle Road to West Hillview Road)
- Haverford Reserve (Lawrence to West Chester to Parkview Road)

Please email us for a list complete with directions.

We are happy to have you join us and look forward to working with you and your family. Please raise your questions and concerns as soon as they arise so that we may address them as quickly and efficiently as possible. It is our hope that this is a positive experience that will have will make positive changes for your family.

Important Contacts

Patricia Gonzalez, LPC, MT-BC, Administrator & Privacy Officer	trish@spectrapa.com
Maleita Olson, LCSW, Executive Director	m@spectrapa.com
Karen Weiss, LSW, Intake Coordinator	intake@spectrapa.com
Staff contact information can be found on our website:	***Click Here***

We know that you have many choices in meeting you/your child's behavioral health needs. Thank you for choosing us. We look forward to the opportunity.

Sincerely,

Patricia J. Gonzalez, LPC, MT-BC

Patricia Gonzalez, LPC, MT-BC/ Co-Owner

Maleita M Olson, LCSW

Maleita Olson, LCSW/ Co-Owner

NOTICE OF POLICIES AND PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU/YOUR CHILD MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW THIS NOTICE CAREFULLY.

Welcome to **Spectra Support Services, LLC** (referred to herein as "we"). We hope that we can give you the kind of support and help that you are seeking. This notice describes how we will use you/your child's protected health information and how you can access this information.

You/your child's health record contains personal information about you/your child's health. This information about you/your child that may identify you/your child and that relates to you/your child's past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This "Notice of Policies and Privacy Practices" describes how we may use and disclose you/your child's PHI in accordance with applicable law and the NASW Code of Ethics. It also describes your rights regarding how you may gain access to and control you/your child's PHI. We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this "Notice of Policies and Privacy Practices". We reserve the right to change the terms of our "Notice of Policies and Privacy Practices" at any time. Any new "Notice of Policies and Privacy Practices" will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised "Notice of Policies and Privacy Practices" by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at you/your child's next appointment. We may use you/your child's PHI through the following activities; however, we will first obtain your consent.

How We May Use and Disclose Health Information about You

FOR TREATMENT: PHI may be used and disclosed by those who are involved in you/your child's care for the purpose of providing, coordinating, or managing health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization. We may also contact you to remind you of you/your child's appointments or to provide information to you about treatment alternatives or other health-related benefits and services that may be of interest to you.

FOR PAYMENT: We may use and disclose PHI so that we can receive payment for the treatment services provided to you/your child. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with you/your child's insurance company, reviewing services provided to you/your child to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

FOR HEALTH CARE OPERATIONS: We may use or disclose, as needed, you/your child's PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share you/your child's PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of you/your child's PHI. For training or teaching purposes, PHI will be disclosed only with your authorization.

REQUIRED BY LAW: Under the law, we must disclose you/your child's PHI to you upon your request. Please note, there are special circumstances for disclosing portions of PHI for juveniles between the ages of 14 and 18. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

VERBAL PERMISSION: We may also use or disclose you/your child's information to family members that are directly involved in you/your child's treatment with your verbal permission.

WITH AUTHORIZATION: Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization. We may deny your access to PHI under certain circumstances, but in some cases, this decision may be reviewed.

Your Rights

RIGHT OF ACCESS TO INSPECT AND COPY: You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set". A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about you/your child's care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you/your child. We may charge a reasonable, cost-based fee for copies. If you/your child's records are maintained electronically, you may also request an electronic copy of you/your child's PHI.

RIGHT TO AMEND: If you feel that the PHI we have about you/your child is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer if you have any questions.

RIGHT TO AN ACCOUNTING OF DISCLOSURES: You have the right to request an accounting of certain disclosures that we make of you/your child's PHI. We may

charge you a reasonable fee if you request more than one accounting in any 12-month period.

RIGHT TO REQUEST RESTRICTIONS: You have the right to request a restriction or limitation on the use or disclosure of you/your child's PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.

RIGHT TO REQUEST CONFIDENTIAL COMMUNICATION: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.

BREACH NOTIFICATION: If there is a breach of unsecured protected health information concerning you/your child, we may be required to notify you of this breach, including what happened and what you can do to protect yourself/your child.

RIGHT TO A COPY OF THIS NOTICE: You have the right to a copy of this notice.

WITHOUT AUTHORIZATION

The following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you/your child without your authorization only in a limited number of situations. Since all or our work is overseen by a social worker licensed in this state and as a member of the National Association of Social Workers, it is our practice to adhere to more stringent privacy requirements for disclosures without an authorization. The following language addresses these categories to the extent consistent with the *NASW* Code of Ethics and HIPAA.

CHILD ABUSE OR NEGLECT: We may disclose you/your child's PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.

JUDICIAL AND ADMINISTRATIVE PROCEEDINGS: We may disclose you/your child's PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

DECEASED PATIENTS: We may disclose PHI regarding deceased patients as mandated by state law. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate.

MEDICAL EMERGENCIES: We may use or disclose you/your child's protected health information in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

FAMILY INVOLVEMENT IN CARE: We may disclose information to close family members or friends directly involved in your child's treatment based on your consent or as necessary to prevent serious harm.

HEALTH OVERSIGHT: If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payers based on your prior consent) and peer review organizations performing utilization and quality control.

LAW ENFORCEMENT: We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

SPECIALIZED GOVERNMENT FUNCTIONS: We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your child's PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

PUBLIC HEALTH: If required, we may use or disclose you/your child's PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

PUBLIC SAFETY: We may disclose you/your child's PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

RESEARCH: PHI may only be disclosed after a special approval process.

Additional Authorizations

We will require a separate authorization from you for disclosures that occur beyond the general consent for treatment, payment, and health care operations. We will obtain an authorization from you prior to releasing any information that goes outside of these general purposes. Included in this level of privacy is your psychotherapy notes (session notes made by your therapist) which is kept separate from the rest of your record as these notes receive a greater degree of protection.

Revoking Your Authorization

You may revoke an authorization at any time by providing us with a revocation in writing. You may not revoke an authorization in the event that 1) we relied on that authorization or 2) the authorization was obtained as a condition of obtaining insurance coverage which then provides the insurer the right to contest the claim under the policy.

You/your Child's Rights and Responsibilities

When you/your child receives service from Spectra Support Services, LLC you have the right to:

- receive high-quality service.
- be treated with respect and courtesy.
- have your information kept private and confidential except as described in Spectra Support Services, LLC "Notice of Policies and Privacy Practices".
- be listened to and have staff work with you to make a plan to address your concerns and needs.
- receive service in offices that are safe, clean and accessible.
- get information and support to help you make decisions to improve your situation
- be served without discrimination.
- discuss your service with staff to identify if it is working for you and express any questions or complaints that you may have.
- request a change of staff member if there is another staff person available who can address your issues and your request is reasonable.
- file a grievance at any time. A "Service User/Complaint Grievance Form" is included in this packet, or request a form from any staff member, or contact our Privacy Officer Patricia Gonzalez, LPC with your concerns.

Complaint/Grievance Process

You have the right to file a complaint if you believe we violated you/your child's rights. We will not retaliate against you for exercising your right. You have the right to file a complaint in writing with our Privacy Officer or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257.

Spectra Support Services, LLC offers a formal Service User Complaint/Grievance Process:

- Service Users and/or their caregivers and advocates are encouraged to share all concerns directly with the staff member providing the service. This can be done verbally, by telephone, or in writing. A complaint form and explanation of the complaint/grievance process are provided during the intake process. Spectra Support Services, LLC makes sure that the Service User and family members understand their rights. If accommodations (e.g., large print, language/ASL interpreter) are needed to assure comprehension, Spectra Support Services, LLC will seek to provide such assistance.
- Service Users or their advocates may also download the Service User Complaint form directly from the agency website or receive a hard copy from any staff member.

- These forms can be handed to any staff person, called-in by phone to the agency main number 484-450-6476 or faxed confidentially to 484-224-3398. Email is not recommended because of confidentiality and security issues.
- Should the Service User need assistance with filing a complaint for any reason, they may request assistance at any time from one of the agency's social workers.

What Spectra Asks of You

- Treat the staff and others at Spectra Support Services, LLC with courtesy and respect.
- Let Spectra Support Services, LLC know 24 hours before if you cannot come to an appointment.
- Inform staff members before terminating treatment so we can work with you to develop an appropriate discharge plan.

Privacy Officer

Contact our privacy officer if you have questions about this notice, disagree with a decision made regarding access to your records, have concerns about your privacy rights, or wish to file a grievance. The Privacy Officer for Spectra Support Services, LLC is Patricia Gonzalez who can be contacted at trish@spectrapa.com, or 484-450-6476, extension 701.

THE EFFECTIVE DATE OF THIS NOTICE IS MARCH 2012.

PSYCHOLOGICAL EVALUATIONS

Thank you for choosing Spectra Support Services, LLC for your psychological evaluation needs. We are committed to helping you answer the questions that have brought you to us for this evaluation. The following will provide you with information relating to the psychological testing process. Should you have any questions or would like to schedule an evaluation contact our intake coordinator Karen Weiss, LSW at intake@spectrapa.com or call 484-450-6476, extension 710.

Spectra Support Services, LLC offers the following Psychological Evaluations

- Autism Spectrum Disorder (Including the administration of the ADOS-2)
- Attention Deficit Disorder
- Mood Disorders
- Personality Disorders
- Capacity Evaluations

Evaluator's Credentials

Karen L. Kampmeyer, Ph.D. conducts psychological assessments at Spectra. She is a licensed psychologist in Pennsylvania, holding a doctorate from the University of Georgia. She evaluates clients referred from therapists or from outside sources for diagnostic clarification, including Autism Spectrum Disorder, Attention Deficit, Mood Disorders, and Personality Disorders. She is an approved provider for Medical Assistance as well as most private mental health insurers in the area.

Your Rights

- You have the right to know the test results, interpretations, and recommendations.
- You have the right to a copy of the final report and evaluation.
- You have the right to interrupt or discontinue the testing process at any time.
- You have the right to disagree with the conclusions of the report.
- You have the right to submit a typed addendum to be considered for your file. If accepted, this would be stored along with your report along with the psychologist's comments and/or disagreements. This addendum will become part of the report and sent together in all future releases.
- You have the right to appeal a rejected addendum with the clinical director of the agency Patricia Gonzalez, LPC, MT-BC at 484-450-6476 Ext. 701.

What to Expect

The assessment process may involve an informational interview followed by an administration of one or more educational and/or psychological tests. The length of time the tests take depend on the evaluation being administered. Usually, participation in testing will take anywhere from 2-5 visits. The visit frequency and duration depends on the type of evaluation being conducted. Once testing is completed, the licensed psychologist will analyze the data and will compose a comprehensive written report. You will then have the opportunity to meet with the psychologist to discuss the results and receive a copy of the report.

Evaluation Costs & Insurance Coverage

Some insurance plans require copay for each visit. Typically, psychological evaluations are conducted over 2-5 visits and more may be required. Some insurance carriers require preauthorization for psychological testing. Your second appointment will not be secured until the pre-authorization is secured by Spectra. We accept payments in the form of cash, checks or credit/debit cards. Please contact Jennifer Guinto from our billing department with any questions related to evaluation costs and insurance coverage at billing@spectrapa.com or call 484-450-6476 x 707.

Release of Records

Spectra Support Services, LLC will release records only upon receipt of a signed consent where you specifically authorize the name(s) or entities to release verbally or in writing information regarding any medical, legal/court records, educational records, mental health and/or alcohol/drug abuse diagnosis or treatment recommended or rendered to the client. To consent to the release of information between our Spectra staff and our licensed psychologist please complete the "Protected Health Information (PHI) Authorization Consent Form" which is included in this packet.

Limits of Confidentiality

Refer to Spectra Supports Services, LLC's "Notice of Policies and Privacy Practices" for information related to the limits of confidentiality. This document includes information about you/your child's rights and the types of circumstances in which PHI maybe released without permission. Please note that all staff at Spectra Support Services, LLC are mandated reporters and will be required to disclose information to appropriate authorities or parties authorized by law.

SPECTRA
support services, llc

FEES FOR SERVICE – PRIVATE PAY

These rates are in effect for all clients who begin service after 01/01/2018. Variable rates are dependent upon the experience of the clinician providing the service.

Service	Rate
Consultation	$150.00 per hour (Maleita Olson, LCSW) $50.00 - $125.00 per hour (other clinicians)
In-home Behavior Support	$80.00 per hour
Family Education/ Navigation	$45.00 to $125.00 per hour
Forms (e.g., Social Security, etc.)	$75.00 per hour
Functional Behavior Analysis	$250.00 - $500.00
Group Education	$50.00 per hour
Job Coaching	$50.00 per hour
Life Skills (in-home)	$35.00 to $50.00 per hour
Psychological Evaluations	Varies
Psychotherapy - Individual (includes Play Therapy, Music Therapy)	$125.00 per hour (licensed clinician) $75.00 per hour (board certified clinician) $75.00 per hour (pre-licensed clinician) Varies per hour (therapist-in-training and supervisor)
Psychotherapy – Group (includes Music Therapy)	$50.00 per hour (licensed clinician) $35.00 per hour (pre-licensed clinician) Varies per hour (therapist-in-training and supervisor)
Psychotherapy Intake	$190.00 for 90 Minutes (licensed clinician) $100.00 for 90 Minutes (pre-licensed clinician)
Social Education/ Life Coaching (individual)	$75.00 per hour
Social Skills Groups	Varies
Vocational Assessment	$250.00 - $350.00
Clinical Supervision – Individual	$125.00 per hour
Clinical Supervision – Group	$75.00 per hour

Discounts on groups are sometimes offered. Please see promotional materials for that particular group session. Sliding scales are available for some services with some clinicians. These services are sometimes reimbursable by some insurance companies as an in or out-of-network provider if your clinician is licensed. We will inform you of your insurance benefits at intake. Check our website for an up-to-date list of participating providers. Invoices may be provided upon request.

URGENT CARE / CRISIS INTERVENTION POLICIES

Clients who are in need of urgent care can contact our "on call" staff via our dedicated urgent care phone line at: **(484) 450-6476, extension 4**. This line is staffed from 7 AM to 11 PM daily by therapists.

When possible, staff on the urgent care line will schedule an urgent visit within 24 hours. If this is not possible, the staff will facilitate the proper referral to other community resources.

If an urgent need occurs between the hours of 11 PM to 7 AM, you are encouraged to contact your county crisis intervention resources, call 911, or utilize the nearest emergency room.

Community Resources

DELAWARE COUNTY CRISIS INTERVENTION

Delaware County Crisis Connections Team: This mobile team will come to your home.
1-855-889-7827

Psychiatric Crisis Centers
Provide crisis intervention, 24 Hour telephone and walk-in services, as well as Psychiatric Emergency Commitment Procedures.
610-447-7600

Crozer Chester Medical Center
(South and Western part of county)
One Medical Center Blvd.
Chester, PA 19013
610-237-4210

Mercy Fitzgerald Hospital
(North and Eastern Part of county)
1500 Lansdowne Ave.
Darby, PA 19013
215-748-9525

MONTGOMERY COUNTY CRISIS INTERVENTION

Abington Hospital
Crisis Services provided in emergency department and in hospital.
1200 Old York Road
Abington, PA 19001
215-481-2525

ACCESS Services: Children's Crisis Services: They offer crisis hotline support 24/7 to children and adolescents in Montgomery County. The purpose of the program is to help children and families manage crisis successfully through individualized crisis response and planning.
500 Office Center Drive, Suite 100
Fort Washington, PA 19034
Phone: (888) HEL-P414

Montgomery County Emergency Services (MCES): Crisis intervention A mobile team will come to your home.
50 Beech Drive
Norristown, PA 19403
610- 279-6100

CHESTER COUNTY CRISIS INTERVENTION

Valley Creek Crisis Center
Available to Chester County residents 24 hours per day, 7 days per week:
469 Creamery Way,
Exton, PA 19341
Crisis Hotline: 610-280-3270 or 610-918-2100 or 877-918-2100

Consumer-Run Warm Line
866-846-2733

Crisis Residential Program
610-594-1665

PHILADELPHIA COUNTY CRISIS INTERVENTION

DBHIDS Delegate Line:
215-685-6440*
(* Will direct caller to most appropriate service provider. Will dispatch the mobile emergency team if necessary.)

Einstein Hospital
Germantown Community Health Services: Crisis Response Center
1 Penn Blvd.
Philadelphia, PA 19144
215-951-8300

MEMORANDUM: NONDISCRIMINATION IN SERVICES

SUBJECT: Nondiscrimination in Services
TO: Service Users/ Clients
FROM: Maleita Olson, LCSW, Executive Director, Maleita M Olson, LCSW

Admissions, the provisions of services, and referrals of clients shall be made without regard to race, color, religious creed, disability, ancestry, national origin (including limited English proficiency), age, or sex.

Program services shall be made accessible to eligible persons with disabilities through the most practical and economically feasible methods available. These methods include, but are not limited to, equipment redesign, the provision of aides, and the use of alternative service delivery locations. Structural modifications shall be considered only as a last resort among available methods.

Any individual/client/patient/student (and/or their guardian) who believes they have been discriminated against, may file a complaint of discrimination with:

Department of Human Services Bureau of Equal Opportunity
Room 225, Health & Welfare Building PO Box 2675
Harrisburg, PA 17105

PA Human Relations Commission Philadelphia Regional Office
110 N. 8th Street Suite 501
Philadelphia, PA 19107

U. S. Department of Health and Human Services Office for Civil Rights
Suite 372, Public Ledger Bldg.
150 South Independence Mall West Philadelphia, PA 19106-9111

Commonwealth of Pennsylvania DHS Bureau of Equal Opportunity Southeast Regional Office
801 Market Street, Suite 5034
Philadelphia, PA 19107

SPECTRA
support services, llc

CLIENT INTAKE FORM

Name of Client:	
Name of person completing this form:	Relationship to Client:
Client's date of Birth:	Client's Age:
Address:	
Languages:	Email:
Client lives with:	
Client's Occupation or School & Grade:	
History of psychiatric treatment or counseling:	
Current or past drug or alcohol use:	
Significant medical problems:	
Serious illnesses, accidents, surgeries, or hospitalizations in the past:	
Medications currently prescribed:	
Primary Care Physician:	Phone of PCP:
Psychiatrist:	Phone of Psychiatrist:

CLIENT: DOB:

History of Problem

Please describe what concerns you have or concerns you have regarding the client:

How long has the problem existed?

Please describe the reason for a referral for a psychological evaluation/assessment: (What do you hope to learn?)

Have there been any significant stressors for the family: losses, births, deaths, moves, hospitalizations, financial problems, in the last several years?

Please check the symptoms that the child and any family member(s) are currently experiencing. Please indicate to which family member you are referring, as well as duration, and severity.

Symptom	**Who?**	**How Long?**	**Severity:** None 0 Mild 1 Moderate 2 Severe 3
Sadness or Depression			
Suicidal Thoughts			
Sleep Problems			
Changes in Appetite			
Weight Change			
Inability to Concentrate			
Obsessive Thoughts			
Tension and Anxiety			
Panic Attacks			
Memory Problems			
Compulsive Behaviors			
Feelings of Hostility			
Acts of Violence			
Social Isolation			
Strange Thoughts			

Stomach Aches			
Head Aches			
Bed Wetting			
Phobias			

Has the client ever had other psychological, psychiatric, or school-based assessments? *If so, please complete the following:*

Purpose of Evaluation	Date	Evaluated by

Has the client ever received any mental/behavioral health services? _____
If yes, please complete the following:

Type of Service	Provider(s)	Dates Provided

Does the client currently receive support services from someone at Spectra? _____
If yes, please list the name of the Spectra Staff person and the service they provide (ex: individual/family therapy, medication management, Wraparound services.

Spectra Staff Person Name	Service Provided	Service Period (Start & End Date)

Is there anyone else who might be participating in the evaluation or able to provide background or developmental information such as teachers, parents, and partners? _____

CLIENT: DOB:

If yes, then please provide us with the person(s) contact information:

Contact Person Name	Relationship to Client	Contact Person's Phone

Please continue to fill out this page and the next page (p. 20 & 21) if you are a parent/guardian.

Select the statements that reflect the client's current life situation (choose all that apply):

- ❑ Client has two legal guardians
- ❑ Client has one legal guardian
- ❑ Client's biological parents are married
- ❑ Client's biological parents are divorced or were never married
- ❑ Client has adoptive parents
- ❑ Client lives with both legal guardians
- ❑ Client lives with one legal guardian
- ❑ Client lives with (please specify)_____

Main Contact name for client with guardian(s):		
Address:		
Home Phone:	Work Phone:	Mobile Phone:
Does this Main Contact live with the client?		
Please check all that apply: ❑ Parent ❑ Adult Child ❑ Sibling ❑ Spouse ❑ Emergency Contact ❑ Other: _____		
Secondary Contact name for client with guardians (if applicable):		
Address:		

Home Phone:	Work Phone:	Mobile Phone:

Does this Secondary Contact live with the client?	
Please check all that apply: ❑ Parent ❑ Adult Child ❑ Sibling ❑ Spouse ❑ Emergency Contact ❑ Other: _____	
Name of Biological Mother:	Name of Biological Father:
Name of Additional Parent(s): Step-Mother:	 Step-Father:
Other adults who live with child:	

For Parents who are divorced or were never married, please state custody arrangements. (You may be required to provide legal documentation of custody arrangements)

Is ex-spouse (biological parent) aware that you are bring the client to Spectra for treatment?

❑ Yes ❑ No

If no, please describe:

If adopted, does client know of adoption? ❑ Yes ❑ No

What age was the client at the time of the adoption?

Are there any other agencies involved with the family (DCFS, Client Welfare, Courts, etc.)?

❑ Yes ❑ No

If yes, please describe:

Print Client Name: **Client's Date of Birth:**

HIPAA-ACKNOWLEDGEMENT OF RECEIPT

NOTICE OF POLICIES AND PRIVACY PRACTICES

We at Spectra Support Services, LLC are required by law to maintain the privacy of and to provide individuals with the attached Notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to the Notice, please ask to speak with our HIPAA Compliance Officer, Patricia Gonzalez, LPC, in person or by phone at 484-450-6476, ext. 701. If you would like an additional copy of the Notice, at any time, please ask. You may also view the "Notice of Policies and Privacy Practices" on our website.

Please understand that all records, written information, or any electronic data are marked **CONFIDENTIAL**. Client records are maintained with on-line electronic medical record companies that assure HIPAA compliance: Therap Services, LLC, or TherapyNotes. Spectra Support Services, LLC conducts business operations on G-Suite which is a security certified online service. Spectra Support Services, LLC maintains a "Business Associate Agreement" (BAA) to use G-Suite in order to meet HIPAA compliance standards. Our staff are trained on how to practice HIPAA compliance while using online services.

All sessions, including telephone or email contacts are confidential to persons outside of the sessions with some exceptions. Therapists on staff at Spectra may share information with other staff members at Spectra for the purposes of supervision, case coordination, or case consultation.

Your therapist is required by law to report:

- threats of harm to another or oneself.
- domestic violence.
- child or elder abuse.
- when directed by the court.
- per a client or parent/legal guardian's signed release.

Please know you always have the right to ask questions of your therapist(s). Therapy only works if you have trust and confidence in us and feel our care and concern for you.

I hereby acknowledge that I have reviewed the HIPAA Notice of Privacy Practice document.

Signature of Client/ Legally Authorized Representative Date Relationship to Client

SPECTRA
support services, llc

Print Client Name: **Client's Date of Birth:**

INFORMED CONSENT FORM

Informed Consent Statement for Treatment for the Client named above.

Select the statement that applies to your life situation:

- ❑ I attest that I am an adult 18 years of age or older.
- ❑ I attest that I am a juvenile that is at least 14 years of age and under the age 18.
- ❑ I attest that I am the biological parent of the client named above and I am married to the client's other biological parent.
- ❑ I attest that I have full legal custody or guardianship of the client named above and am legally authorized to initiate and consent to treatment on behalf of this individual without the consent of additional parties*. I will produce legal documentation of such upon request.

  **In the state of PA, if both parents/guardians of a child are married, only one parent/guardian is needed for consent. In the event that parents are divorced or were never married, both biological parents/guardians must consent unless a custody/guardianship document from a court of law states otherwise.*
- ❑ I attest that I have joint legal custody of the client named above and I authorize consent to treatment on behalf of this individual. I understand that in the state of PA both parties are required to consent to treatment on behalf of this individual.

Client or Legal Guardian:

I agree and consent to my/the above client's participation in behavioral health care services offered and provided at/by Spectra Support Services, LLC a behavioral health care provider. I understand that I am consenting and agreeing only to those services that the above named provider is qualified to provide within: (1) the scope of the provider's license, certification, and training; or (2) the scope of license, certification, and training of the behavioral health care providers directly supervising the services received by the client. I understand that with my written consent and if therapeutically appropriate, Spectra therapists may involve other adults/caregivers in the therapeutic process whether or not they have legal custody at the time of service.

My signature below represents my consent, agreement, and understanding.

Signature of Client/Legally Authorized Representative Date

Print Client Name: **Client's Date of Birth:**

INFORMED CONSENT FORM - CONTINUED

Client's Representative:
I understand that the client named above has the legal authority to consent to said client's own treatment. I attest that I am the designated representative who advocates for the client's best interests and supports the client in the process of making informed decisions related to consenting to treatment. My signature below represents my agreement with the client's decision to participate in behavioral health care services offered and provided at/by Spectra Support Services, LLC a behavioral health care provider.

Signature of Client's Representative (if applicable) Date Relationship to Client

Client Representative's Address & Phone

Spectra Staff:

I, the designated Spectra staff person, have discussed the issues above with the client and/or the parent, guardian, or representative. My observations of this person's behavior and responses give me reason to believe that this person **is fully competent** to give informed and willing consent.

Signature of Spectra Staff Person Date Job Title

Or

I, the designated Spectra staff person, have discussed the issues above with the client and/or the parent, guardian, or representative. My observations of this person's behavior and responses give me reason to believe that this person **may not have competency** to give informed and willing consent.

Signature of Spectra Staff Person Date Job Title

SPECTRA
support services, llc

Print Client Name: _____ **Client's Date of Birth:** _____

General Consent to Release Information

IMPORTANT: Please indicate your selections by writing your initials.

CONSENT FOR RELEASE OF INFORMATION TO INSURANCE PLAN AND ASSIGNMENT OF BENEFITS:
SELECT ALL THAT APPLY TO THE SERVICES YOU RECEIVE

Initial if you/the client receives therapy from a licensed clinician and you are assigning insurance benefits to Spectra.

_____ **I give consent to Spectra Support Services, LLC to release medical information to my/the client's insurance company/companies.** I certify that the information I have reported with regard to my insurance coverage is correct. I give consent for the release of any necessary medical information for this or any related claims, in writing (i.e. treatment plans) or verbally (i.e. requesting benefit/authorization information by phone). I agree with the assignment of my insurance benefits to Spectra Support Services, LLC. I permit a copy of this consent to be used in place of the original. This consent may be revoked by me at any time in writing. I understand that nothing herein relieves me of the primary responsibility and obligation to pay for medical services provided. If my insurance company limits visits, I accept responsibility for monitoring the number of allowed sessions used. I agree to pay for all non-covered services, including late cancellations/missed appointments, telephone appointments, services provide after benefit exhaustion, and services determined not to be necessary by my insurance carrier.

Complete the following if you are assigning your insurance benefits to Spectra Support Services, LLC.

Primary Insurance Carrier	Member Number (s)	State/Group
Secondary Insurance Carrier	Member Number (s)	State/Group

Initial if you/the client receives therapy from a licensed clinician and insurance benefits will not be assigned to Spectra.

_____ **I <u>DO NOT</u> give consent** to Spectra Support Services, LLC to apply for benefits or to release medical information to my/the client's insurance company/companies. **<u>I accept responsibility for full payment of all services provided according to the private pay fee schedule.</u>** I agree to pay for all out-of-network or non-covered services including later cancellations, missed appointments, telephone appointments. I understand that my benefits will be absent because no information will be released to my insurance carrier.

Initial if you/the client receives therapy from a pre-licensed clinician or services are not reimbursable by insurance.

_____ **I acknowledge that I have chosen services from a pre-licensed clinician or services that are not reimbursable by my insurance.** I accept responsibility for payment of all services provided at the agreed-upon rate. I acknowledge that insurance does not reimburse clinicians without a clinical license or certain services that are not deemed medically necessary. I agree to pay for services including late cancellations, missed appointments, and telephone appointments.

SPECTRA
support services, llc

Print Client Name: _____ **Client's Date of Birth:** _____

General Consent to Release Information - Continued

CONSENT FOR RELEASE OF INFORMATION FOR HEALTHCARE OPERATIONS:

☐ I give consent to Spectra Support Services, LLC to share necessary health information with staff that the agency may hire or contract with as well as software support to assist with billing, scheduling, or other office operations

CONSENT FOR RELEASE OF INFORMATION FOR PURPOSES OF CLINICAL SUPERVISION

☐ I give consent to Spectra Support Services, LLC to share necessary health information with other Clinical Staff members within the agency for purposes of clinical supervision and effective treatment. I recognize that as little information will be provided as is necessary.

POLICY FOR RELEASE OF INFORMATION IN SPECIAL SITUATIONS:

☐ I understand that Spectra Support Services, LLC may disclose health information about me in the event of a serious threat to the health and safety of myself or others, in the event of suspected child abuse or neglect, or in other situations as detailed in the Notice or Privacy Practices.

CONSENT FOR RELEASE OF INFORMATION FOR APPOINTMENT REMINDERS OR SERVICES:

For the purposes of appointment reminders and or setting up future appointments:
Please indicate your selections by writing your initials on the line.

☐ I authorize Spectra Support Services, LLC to contact me by phone at _____.

☐ I authorize Spectra Support Services, LLC to contact me by text at _____.

☐ I authorize Spectra Support Services, LLC to leave a message on voice mail at _____.

☐ I authorize Spectra Support Services, LLC to contact me by email at _____.

☐ I authorize Spectra Support Services, LLC to email me billing statements to the above email address.

☐ I authorize Spectra Support Services, LLC to give me appointment reminders to my email.

My signature below represents my consent, agreement, and understanding.

Signature of Client/ Legally Authorized Representative Date Relationship to Client

SPECTRA
support services, llc

Print Client Name: _____ **Client's Date of Birth:** _____

RESPONSIBLE PARTY ACKNOWLEDGEMENT OF AGENCY POLICIES

Payment Responsibility: I, _____ am financially responsible for the services provided to the client named above.

- My insurance benefits and my co-pays/ charges for services have been explained to me.
- I agree to make payment of all copays/charges **at the time of service**. Payments may be cash or check or credit.
- I acknowledge receipt of the fee schedule and information regarding my insurance coverage (if applicable).
- Cancellation policy: I agree to inform the therapist by voice (to 484-450-6476, extension 2) in the event that I/ the client will not be available with as much notice as possible.
  - **Sessions cancelled with less than 24 hours' notice will be charged a $35.00 fee, no matter the circumstances.**
  - *A client who uses Medical Assistance to pay for a service is not subject to the cancellation fee. However, if the client fails to cancel a total of 3 sessions without sufficient notice can be grounds for immediate termination of services.*
- I understand that in group experiences, there is **no credit for cancelled sessions**. However, the Director may (at her discretion) offer a credit for future individual or group sessions if the client is unable to complete the current session because of extenuating circumstances.
- **Cases of custody disputes:** I acknowledge that Spectra provides therapy in a contextual family framework that affirms the need for children to have contact with family members and to involve them in therapy to the greatest extent possible. To that end, Spectra therapists will not accept voluntary requests to testify on behalf of one parent against another or prepare documents for use in court.
- **Acknowledgement of credentials:** I acknowledge that I have read the therapist's credentials, as described in printed form.
- **Acknowledgement of client rights:** I acknowledge that I have read the Spectra Client Rights and Responsibilities which include my right to file a grievance and been made aware of the on-site location of the more extensive Policy and Procedure Manual for Spectra Support Services, LLC. If applicable, I acknowledge receipt of the following supplemental forms, as required by my insurance carrier: _____.
- **Acknowledgement of Urgent Care/Crisis Intervention Policy:** I acknowledge receipt of the Urgent Care/Crisis Intervention Policy, contact information for the urgent care line, and resources for mental health emergencies.
- **Policy for termination:** I acknowledge that it is my choice to participate/ to have my client participate in therapy services. If I decide to terminate treatment, I will discuss termination before ending treatment so that a proper transition and discharge plan may be developed.

Before you sign below, please ask any questions you may have of this document.

My signature below represents acknowledgment and understanding.

Signature of Client/ Legally Authorized Representative Date Relationship to Client

SPECTRA
support services, llc

Print Client Name: _____ **Client's Date of Birth:** _____

CONSENT TO TREATMENT FOR JUVENILES

COMPLETE THIS CONSENT ONLY IF YOU ARE A JUVENILE: If you are at least 14 years of age and under age 18 in the state of PA, you are considered a juvenile, and may consent to your own mental health examination and treatment. You do not need a parent or guardian's permission to participate in these services. Also, a parent or legal guardian may provide consent for you to receive mental health services without your consent. In either situation, the non-consenting person cannot override the consent of the other person. To learn more about mental health treatment for juveniles in PA **CLICK HERE**. **Please make your selection below after you reviewed this document and/or had a discussion with your therapist.**

JUVENILE CLIENT

(14 years of age and under 18)

- ☐ I, _____ (client), **agree and consent** to participate in behavioral health care services offered and provided at/by Spectra Support Services, LLC a behavioral health care provider.
- ☐ I, _____ (client), **DO NOT agree and consent** to participate in behavioral health care services offered and provided at/by Spectra Support Services, LLC a behavioral health care provider.

Client's Signature Date

PARENT/GUARDIAN

- ☐ I, _____ (guardian/parent), **agree and consent** to have my child participate in behavioral health care services offered and provided at/by Spectra Support Services, LLC a behavioral health care provider.
- ☐ I, _____ (guardian/parent), **DO NOT agree and consent** to have my child participate in behavioral health care services offered and provided at/by Spectra Support Services, LLC a behavioral health care provider. I realize that, by law, my juvenile may continue services without my consent.

Parent/Guardian's Signature Date

Print Client Name: **Client's Date of Birth:**

CONSENT TO TREATMENT FOR JUVENILES - CONTINUED

THERAPIST

- ❑ I, the designated Spectra staff person, have discussed the issues related to treatment with the client and/or parent/guardian. My observations of the responses from the client and parent/guardian give me reason to believe that they are **fully competent** to give informed and willing consent.

- ❑ I, the designated Spectra staff person, have discussed the issues related to treatment with the client and/or the parent, guardian, or representative. My observations of the responses from the client and parent/guardian give me reason to believe that this person **may not have competency** to give informed and willing consent.

Signature of Spectra Staff Person Date Job Title

Print Client Name: **Client's Date of Birth:**

CONSENT TO PSYCHOLOGICAL EVALUATION

Refer to our document "Psychological Evaluations" for further information about this behavioral health service. Please make your selection below after you reviewed this document and/or had a discussion with your evaluator.

- I agree for me or my child to undergo a Psychological Evaluation at Spectra Support Services, LLC.
- I understand that Dr. Karen Kampmeyer is contracted by Spectra Support Services, LLC to complete this evaluation.
- I have been informed of the policies regarding evaluations at the agency.
- I read this consent form and Spectra's "Notice of Policies and Privacy Practices" and fully understand my/my child's rights.
- I understand that I have the right to discontinue the evaluation process at any time. However, I understand that Spectra Support Services, LLC may be unable to provide feedback of the test results if testing is terminated. Additionally, I understand that I will continue to be responsible for payment of any testing, scoring, and evaluation time provided up until that point.
- I understand an evaluation may include information from me/my child relating to behavioral observations, information provided, and tests completed.
- I understand that my/my child's PHI will be released only to the persons or parties for which I provide signed consent for.
- I understand that me or my child's PHI may be used and disclosed by supervising staff involved in you/your child's care for the purpose of providing, coordinating, or managing care (i.e. treatment, payment, health care operations).
- I understand that I can refuse to consent to the release of my or my child's PHI at any time.
- I understand that the results and report of my/my child's evaluation will be retained in a file by Spectra Support Services, LLC, and securely stored for a time period mandated by PA state law.

My signature below represents acknowledgment and understanding.

Signature of Client/Legally Authorized Representative Date Relationship to Client

SPECTRA
support services, llc

Print Client Name: _____ **Client's Date of Birth:** _____

PAYMENT AUTHORIZATION FORM

Schedule a payment toward the above named client's account by using your Visa, MasterCard, American Express or Discover Card. Just complete and sign this form to get started.

Here's How Your Payment Works:
You authorize us to make a charge to your debit/credit card for the amount indicated below. The charge will appear on your bank statement and a receipt for the payment can be sent to you upon request. The payment will be credited toward the account of the client named above.

Please complete the information below:

I _____ authorize Spectra Support Services, LLC to charge my debit/credit card account

indicated below for $_____ for services that were provided to the client named above.

_____

Name of Card Holder Relationship to Client

_____

Billing Address Street City State Zip

_____

Phone Email

Credit/Debit Card

☐ Visa ☐ MasterCard ☐ Amex ☐ Discover

Cardholder Name _____

Account Number _____

Exp. Date _____

CV Number: _____

Signature **Date**

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Spectra Support Services, LLC in writing of any changes in my account information or termination of this authorization at least 15 days prior to the anticipated day of a charge. I certify that I am an authorized user of this credit/debit card and will not dispute these scheduled transactions with my debit/credit card company; so long as the transactions correspond to the terms indicated in this authorization form.

SPECTRA
support services, llc

Print Client Name: _____ **Client Date of Birth:** _____

PROTECTED HEALTH INFORMATION (PHI) AUTHORIZATION FORM

Client's Rights

- You may end this authorization (permission to use or disclose information) any time by contacting our office.
- If you make a request to end this authorization, it will not include information that may have already been used or disclosed based on your previous permission.
- You will not be required to sign this form as a condition of treatment, payment, enrollment, or eligibility for benefits.
- You have a right to a copy of this signed authorization.
- If you choose not to agree with this request, your benefits or services will not be affected.

Client Authorization

I hereby authorize the name(s) or entities written below to release verbally or in writing information regarding any medical, legal/court records, educational records, mental health and/or alcohol/drug abuse diagnosis or treatment recommended or rendered to the above identified client/patient. I authorize these agencies to share information by mail, phone, in person, fax and/or email contact. I understand that these records are protected by Federal and state laws governing the confidentiality of mental health and substance abuse records, and cannot be disclosed without my consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time and must do so in writing. A request to revoke this authorization will not affect any actions taken before the provider receives the request.

I, _____ authorize Spectra Support Services, LLC to ☐ **RELEASE** *AND/OR* ☐ **OBTAIN** my/the client's PHI from

Name/Entity: _____

Address: _____

Phone/Fax: _____

Disclosure may include the following verbal or written information: (check all that apply)

- ☐ Behavioral health/psychological consult
- ☐ Discharge summary
- ☐ Progress & case notes
- ☐ Psychosocial assessment/family history
- ☐ Summary of treatment records & contact dates
- ☐ Psychological evaluation/testing results
- ☐ Information necessary to identify, diagnose, or treat for mental health, substance abuse (alcohol/drug use), and any other relevant information for the purpose of treatment.
- ☐ Other: _____

All information I hereby authorize to be obtained from the above identified source will be held strictly confidential and cannot be released by Spectra Support Services, LLC without my written consent. I understand that this authorization will remain in effect for:

- ☐ The period necessary to complete all transactions on accounts related to services provided to me.
- ☐ One (1) year
- ☐ Other: _____

I understand that unless otherwise limited by state or federal regulation and except to the extent that action has been taken which was based on my consent, I may withdraw this consent at any time. If client is a minor child or an adult with a guardian, I verify that I am the legal guardian/custodian of this client and have the authority to consent. My signature below represents my consent, agreement and understanding.

Signature of Client/ Legally Authorized Representative Date Relationship to Client

SERVICE USER COMPLAINT/GRIEVANCE FORM

You have the right to file a complaint if you believe we violated you/your child's rights. **We will not retaliate against you for exercising your right.** You have the right to file a complaint in writing with our Privacy Officer at 484-450-6476 Ext. 701 or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257.

Please use this form to file a complaint or grievance. Once completed please enclose this form in an envelope and address it to the attention of our Privacy Officer Patricia Gonzalez. To secure your privacy we request you send by fax 484-224-3398 or by mail 475 Lawrence Road, Broomall, PA 19008.

Service User or Community Member Information	
Name:	
Phone:	
Address:	
Please indicate your selections by writing your initials on the line _____ I authorize Spectra Support Services, LLC to contact me by phone. _____ I authorize Spectra Support Services, LLC to leave me a voice message. _____ I authorize Spectra Support Services, LLC to contact me by mail.	
Complaint Information	
Date:	Date of Event where Issue Occurred:
Please list your issue(s):	
Please describe any actions you took to address this issue(s):	
Please provide a brief description about the circumstance and situation leading up to the issue.	
Feel free to list any solutions you would like to see in response to your issue(s).	

Signature Date